

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19 20 and 21, 2014</p> <p>Facility number: 000578 Provider number: 155627 AIM number: 100267810</p> <p>Survey Team: Karen K Koeberlein, RN, TC Julie Dover, RN Jason Mench, RN Kim Davis, RN</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 1 Medicaid: 23 Other: 3 Total: 27</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 26, 2014,</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000279 SS=D	<p>by Jodi Meyer, RN 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for 1 of 2 residents reviewed for care plans regarding level II recommendations. (Resident #15).</p> <p>Findings Include:</p> <p>The clinical record of Resident #15 was reviewed on 2/19/14 at 8:00 a.m. The record indicated the resident's diagnoses included, but</p>	F000279	F-Tag 279 Comprehensive Care Plans It is the policy of Miller's Merry Manor, Wabash West to use the results of the assessment to develop, review, revise the resident's comprehensive plan of care. The health care plans for resident #15 have been reviewed and updated accordingly. All residents are at risk to be affected by the deficient practice. No other resident issues have been identified. The facility will continue to develop a comprehensive plan of care for each resident that includes objectives and timetables to meet	03/23/2014	

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	<p>were not limited to, Alzheimer's disease, bipolar disorder, schizophrenia, diabetes, and lung disease.</p> <p>"The State of Indiana Certification of PASRR/MI Pre Admission Screening Determination", dated 6/10/11 was reviewed. The PASRR/MI level II identified Resident # 15 was mentally ill, the recommendations were for required yearly reviews.</p> <p>The Care Plan dated 12/19/13, no care plan for the yearly review in response to the recommendations of the level II was developed.</p> <p>The Social Service Director (SSD) was interviewed on 2/19/14 at 8:40 a.m. The SSD indicated Resident #15 was admitted on 8/21/13 from another facility. The SSD was unaware the yearly review had not been completed.</p> <p>The SSD was interviewed on 2/19/14 at 10:05 a.m. The SSD indicated she had not developed a Care Plan for the yearly reviews for Resident #15.</p> <p>3.1-35(a)</p>		<p>the resident's medical, mental, psychosocial, and nursing needs as identified by the comprehensive assessment. The last completed comprehensive assessment on each resident identified with level II recommendations will be reviewed and utilized to ensure the plan of care is reflective of the residents needs as identified by the comprehensive assessment. To ensure this deficient practice does not recur The MDS coordinator will be responsible to complete the quality assurance tool "RAI process/MDS review" (Attachment A) on a random sample of 1/3 of the resident population monthly for the next three months then quarterly thereafter. Any identified issues will be addressed immediately and logged on the "Quality Assurance Problem Log" (Attachment B) This will be reviewed and followed through the monthly facility Quality Assurance meeting. Date of Compliance: 3-23-14.</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physicians orders were followed regarding a dressing change for 1 of 1 residents reviewed for physician orders. (Resident #18)</p> <p>On 2/19/14 at 11:15 a.m. RN #1 was observed changing a wound dressing on Resident #18. RN #1 placed the bag of dressing supplies on the floor at the residents feet. RN #1 had gloves on as she raised the residents pant leg, then she took the old dressing off and placed it on the floor, then she opened the package of sterile cotton swabs.</p> <p>She then opened the tube of Bactroban ointment (antibiotic ointment) and applied the Bactroban to the cotton swab then used the cotton swab to apply the Bactroban to open area on left leg.</p> <p>RN #1 opened the packaging to the adherent dressing she then reached into her pocket for a marker and</p>	F000282	F282 Services by Qualified Person/Per Care Plan: It is the policy of Miller's Merry Manor, Wabash West that all services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Resident #18 had no adverse effects related to this cited deficiency. All residents have the potential to be affected by this deficient practice. No other issues have been identified. All residents with treatment orders in place have been reviewed along with the plan of care. RN #1 was re-educated regarding the P/P for dressing changes on 2/21/14. All nurses will be re-educated on the P/P for dressing changes and also for following resident plan of care for treatment on or before 3/7/14. To ensure this deficient practice does not recur the DON/Designee will complete random audits utilizing the tool "Dressing Change Treatment Procedure" (Attachment F) with nurses weekly for the next 3 weeks, then monthly x3 and then quarterly thereafter. Issues identified will be addressed immediately with the staff and	03/23/2014	

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	<p>wrote 2/19/14 and her initials on new adherent dressing then placed on residents leg.</p> <p>RN #1 then pulled the residents pant leg down. All of that was done wearing the same pair of gloves.</p> <p>RN #1 then removed left glove folding old dressing, cotton swab and adhesive backing into the glove then removed glove from right hand and placed in the waste basket.</p> <p>RN #1 went to the resident's bathroom to wash hands. RN #1 washed her hands for greater than 20 seconds. RN #1 picked up the bag of dressing supplies and left the room.</p> <p>On 2/19/14 at 11:25 a.m. RN#1 indicated that she should have placed the waste basket with in reach while doing dressing change in order to throw old dressing away instead of placing it on the floor.</p> <p>On 2/19/14 at 1:30 p.m. medical record was reviewed for Resident #18. The physician's order for the dressing change dated 2/3/14 indicated to apply "...Bactroban and non adherent dressing with Kerlix daily until healed."</p> <p>3.1-35(g)(2)</p>		<p>education/guidance provided. All issues will be documented on the "Quality Assurance Problem Log" (Attachment B). The Quality Assurance Problem Log will be brought to QA monthly and reviewed and followed in the monthly facility Quality Assurance meeting. Date of Compliance 3-23-14</p>		

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview, observation and record review, the facility failed to ensure residents were free of unnecessary medications for 4 of 5 residents reviewed for unnecessary medications regarding antidepressant medications. (Residents #3,#15, #26 and #27)</p> <p>Findings Include:</p> <p>1. The clinical record of resident #15</p>	F000329	F-Tag 329: Unnecessary Medications: It is the policy of Miller's Merry Manor, Wabash West that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, without adequate indication for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons. Resident #8: Medication regimen has been reviewed by physician	03/23/2014			

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	<p>was reviewed on 2/19/14 at 9:50 a.m. The record indicated the resident's diagnoses included, but were not limited to, schizophrenia and bipolar disease, and depression.</p> <p>The physician orders signed on 2/3/14, included an order for 100 milligrams (mgs) of the antidepressant, Zoloft, to be given daily for depression. The medication original date was 8/26/13.</p> <p>The care plan, dated 12/9/13, indicated the resident had a diagnosis of depression. The care plan interventions included the administration of medication and monitor for side effects of the medication.</p> <p>The "Facility Behavior/Psychotropic Med [medication] Quarterly Review" completed by the Social Service Director (SSD) on 1/24/14, indicated, Resident #15's Zoloft was started before admission. The medication review indicated dose reductions were not required. The medication review indicated the target symptoms for the Zoloft were tearfulness and mood decline. The med review indicated, "... 7. Any episodes of worsening depressive</p>		<p>to ensure that resident is free from unnecessary medication. All residents who are prescribed psychoactive medications are at risk to be affected by the deficient practice. The DON/Designee will complete an audit of all active residents to ensure proper indication and diagnosis for use of any prescribed psychoactive medications by 3/23/14. The pharmacy consultant will continue to make monthly visits to complete onsite drug regimen reviews and will submit recommendations for drug reductions to the DON. The DON/Designee will be responsible to communicate pharmacy recommendations to the physician and ensure timely physician response/follow up. The facility policies for "Behavior Assessment/Management Program" and "Psychotropic Drug Use" will be reviewed with all nursing staff by 3/23/14. The facility will continue to have monthly behavior meetings to review residents who are prescribed psychoactive medications, behavior patterns/target behaviors, pertinent diagnosis for use, and ensure physicians are notified of any pharmacy recommendations for GDR's. Resident specific interventions will be reviewed for effectiveness and changes will be made as needed to the resident's plan of care. To ensure that residents are not receiving</p>		

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	<p>behavior, suicidal thinking in past quarter.". The answer indicated, "0 [none] noted since admission".</p> <p>2. The clinical record of Resident #27 was reviewed on 2/18/14 at 8:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, depression, senile dementia with depressive features, and kidney disease.</p> <p>The physician orders signed on 2/3/14 included an order for the 20 milligrams (mgs) of the antidepressant, Celexa to be given every night for depression. The order was dated 4/15/13.</p> <p>The care plan dated 12/31/13 indicated Resident #27 had a diagnoses of depression. The care plan interventions included, administering the medication and monitoring for side effects of the medication.</p> <p>The monthly pharmacist reviews were presented by the nurse consultant on 2/19/14 at 1:00 p.m. The pharmacy reviews did not include information regarding the Celexa.</p> <p>The "Facility Behavior/Psychotropic</p>		<p>unnecessary psychoactive medication the DON/Designee will complete the audit tools "Behavior/Antipsychotic Medication Review, Psychopharm Med Review, and Sedative/Hypnotic Med Review" (Attachments C,D,E) on 1/3 of the resident population monthly x3 and then quarterly thereafter on all residents receiving psychoactive/psychopharm drugs. Any issues identified will be addressed immediately and logged on the "Quality Assurance Problem Log" (Attachment B). The Quality Assurance Problem Log will be reviewed and followed in the monthly facility Quality Assurance meeting. Date of Compliance: 3/23/14 F-329 Unnecessary Medications Miller's Merry Manor, Wabash West respectfully requests to informally dispute this citation via paper review. This citation is being disputed as each antidepressant medication identified on the CMS-2567 does not meet the regulatory definition of an unnecessary medication. "An unnecessary drug is any drug when used: · In excessive dose (including duplicate therapy) or · For excessive duration or · Without adequate indications for its use or · In the presence of adverse consequences which indicate the dose should be reduced or discontinued or · Any combination of reasons</p>				

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	Med [medication] Quarterly Review" dated 12/11/13, completed by the Social Service Director (SSD) indicated, "... Antidepressants for depression only-No behavior tracker required if used for depression document effectiveness with initiation, and dosage changes...Started Celexa 20 mg po [by mouth], qhs [every hours sleep] 01/21/12, decreased on 07/24/2012 to Celexa 10 mg po qhs. Increased Celexa on 04/15/2013 d/t [due to] situational depression. Celexa 20 mg po qhs...".		above." Each example of non-compliance within F-329 deals with the administration of an antidepressants used for the signs and symptoms of depression and not for behaviors. 1. Resident #15 – Diagnosis of Bipolar Schizophrenia, Depression. Resident #15 has had life long mental illness and multiple inpatient stays for such. Resident most recently had inpatient treatment at a geriatric psychiatric unit for psychotic paranoia related to her diagnosis in August of 2013. She is closely followed by Rounding Providers, a geriatric psychiatric nurse practitioner consulting group. (Attachments 1 & 2) and also takes Risperdal, of which was recently reduced.(Attachments 3 & 4) Due to mental illness and notation of depression during November and December 2013 visits, dose reduction of Zoloft is not appropriate as with continued use of this medication Resident # 15 has not displayed any symptoms of depression and has been doing well psychosocially as noted in attachments 3 & 4. Resident #15 care plan addressing her depression includes non-pharmalogical interventions (Attachment 5) Excessive dose? - No - Zoloft 100mg daily is appropriate dosing for elderly according to manufacturer's instructions. Excessive duration? – No – Resident had depressive		

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			<p>symptoms in November and December 2013, with improvement noted since that time while taking the Zoloft 100mg. Without adequate indications for use? – No – Resident has major mental illness of Bipolar Schizophrenia with Depression and long documented history of these illnesses. Without adequate monitoring? - No – Resident is assessed and monitored for symptoms of depression on an ongoing basis by staff. Symptoms of depression are not tracked on behavior tracking logs as these symptoms are not behaviors. Mood is monitored via geri psych nurse at monthly visit, interdisciplinary quarterly review of psychotropic medication reviews completed July, September and December 2013, MDS completed 7/4/13, 7/30/13 , 9/10/13, 12/4/13 and 2/27/14 and Social Service Assessments 7/1/13, 7/30/13, 9/10/13, 12/4/13 and 2/26/14 all assessing for signs and symptoms of depression. In presence of adverse consequences? – No – Resident is presently at her highest functional, mental and psychosocial well-being since admission mid-2013. She is pleasant, social, involved in activities, out of her room most of the day and eating well. Any combination of reasons above? - No Therefore, the continued use of Zoloft 100mg daily is</p>		

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			<p>appropriate and does not constitute an unnecessary medication according to regulatory guidelines. 2. Resident #27 – Diagnoses – Depression and Senile Dementia with Depressive features. Resident #27 is being treated with Celexa 20mg at bedtime for depression. Her care plan for depression includes non-pharmalogical interventions in addition to the medication administration and monitoring for side effects (Attachment 6) Excessive Dose? – No – Celexa 20mg daily is appropriate dosing for the elderly according to manufacturer's instructions. Excessive Duration? – No – Dose reduction was completed and then increased due death of roommate April 2013. Resident is free of symptoms of depression, so continued use is appropriate. Without adequate Indication for use? – No – Resident # 27 has diagnosis of Depression Without Adequate Monitoring? – No – Staff assesses and monitor for signs of depression on an ongoing basis. Behavior tracking is not completed as this medication is used for symptoms of depression, not behaviors. In addition, Interdisciplinary Quarterly Psychotropic Medication reviews were completed 4/15/13, 7/10/13, 9/26/13 and 12/11/13, Social Service assessments completed on 3/29/13, 7/1/13,</p>		

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			9/26/13 and 12/23/13 and MDS completed 4/1/13, 7/1/13, 9/30/13 and 12/24/13 all assessing for signs and symptoms of depression. In presence of adverse consequences? – No- Resident is free of adverse consequences and remains free of signs and symptoms of depression, which is the purpose of the medication. Any combinations of reasons above? - No Consultant pharmacist did not note the use of Celexa on the Drug Regimen Recommendation as the medication is appropriate, effective and not a concern. The use of Celexa was included on the psychotropic medication log completed by the pharmacist on each monthly visit. Resident #27 use of Celexa 20mg daily for the treatment of depression does not constitute an unnecessary drug according to regulatory guidelines. 3. Resident #3 – Diagnoses – Osteoarthritis, Heart Failure, Hypertension, Depression and Insomnia. Resident #3 is taking Remeron 7.5mg for the treatment of depression that originally was manifested by lack of appetite, weight loss, withdrawal and sadness in 2008. This resident is 103 years old and has a BIMS score of 15. The use of this medication has greatly improved her quality of life. She is pleasant, social, eating well, active in facility events and the		

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			<p>Resident Council president. She has maintained a high well being physically, mentally and psychosocially. Reduction of this medication was not felt to be in this 103 year olds best interest considering what her status was prior to initiation of this antidepressant. This medication is used for signs and symptoms of depression and not behaviors. Resident was observed napping with a pencil in her hand. Many residents, particularly those 103, nap throughout the day.</p> <p>Excessive Dose? – No. Remeron 7.5mg does not exceed appropriate dosing for the elderly according to manufacturer's instructions. Excessive Duration? – No – Considering this resident is 103 and looking back to the vast improvement in her overall functional, mental and psychosocial since starting this medication years ago. Her quality of life has been improved since the Remeron was started.</p> <p>Without adequate indications for use? – No – Resident #3 has diagnosis of Depression Without Adequate Monitoring? – No – Staff assesses and monitor for depression on an ongoing basis. CMS 2567 states "no documented episodes of depression could be found in Resident #3's record." Why would we want to see episodes of depression? Absence of documentation of episodes of depression validates the</p>	

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			antidepressant is effective, the desired effect. Interdisciplinary Quarterly Psychotropic Medication reviews were completed 5/30/13, 8/14/13, 11/25/13 and 2/10/14. Social Service assessments were completed 5/29/13, 8/29/13, 11/21/13, 2/19/14 and MDS were completed 5/30/13, 8/30/13, 11/29/13 and 2/20/14 all assessing for signs and symptoms of depression. In presence of adverse consequences? – No – Resident is doing extremely well and observed napping does not indicate an adverse consequence. Any combination of reasons above? – No Resident #3, a 103 year old Resident Council President, is taking Remeron shown to be effective in treating her depression; is appropriate for continued use, is being monitored for effectiveness and does not constitute an unnecessary drug in accordance to regulatory guidelines. 4. Resident # 26 with diagnosis of Depression is being treated with Lexapro 10mg daily. This antidepressant is being used to treat signs and symptoms of depression and not behaviors. Resident has had unsuccessful GDR while being hospitalized and further reductions are likely to result in actual emotional and psychosocial harm based upon this resident's previous history with dose reductions. Excessive		

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			<p>Dose? – No – Lexapro 10mg daily is appropriate dosing for the elderly according to manufacturer's instructions.</p> <p>Excessive Duration? – No – Based upon history of unsuccessful GDR, this drug is medically necessary for resident #26. Resident is presently at her highest emotional and psychosocial well being. Without Adequate Indications for use? – No – Resident is diagnosed with Depression Without Adequate Monitoring?- No – Staff assess and monitor for signs of depression on an ongoing basis. This medication is used to treat signs of depression, not behaviors; so behavior tracking is not indicated. Interdisciplinary Quarterly Psychotropic Medication Reviews were completed 5/20/13, 8/13/13, 10/7/13 and 2/10/14. Social Service assessments were completed on 5/14/13, 8/15/13, 11/5/13 and 2/4/14 and MDS completed on 5/15/13, 8/15/13, 11/5/13 and 2/5/14 all assessing for signs and symptoms of depression. In the presence of adverse consequences? - No – Resident #26 is doing well. Any combinations of reasons above? – No Resident #26 is being treated for Depression with Lexapro, which has been effective in controlling symptoms. The continued use of this antidepressant is appropriate and does not constitute unnecessary</p>		

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	<p>3. The clinical record for Resident #3 was reviewed on 2/18/14 at 11:30 a. m. Diagnoses included, but were not limited to, osteoarthritis, congestive heart failure, hypertension, depression, and insomnia.</p> <p>Physician's orders reviewed on 2/18/14 at 11:35 a. m., indicated Resident #3 had a current physicians order for Remeron (an antidepressant) tablet, 7.5 milligrams daily at bedtime. The physicians order listed the original start date as 8/15/2008.</p> <p>Resident #3 had a current comprehensive care plan dated 11/26/2013. The care plan addressed Resident #3's use of the</p>		<p>medications in accordance to regulatory guidelines. 5. The policy of Miller's Merry Manor for Psychotropic Medication Use (attachment 9)has been reviewed by multiple federal and state surveyors since the CMS revision of F-329 in 2006. The policy indicates behavior tracking will not be completed for the use of anti depressants in the treatment of depression. This portion of the policy has never been questioned or cited by surveyors. Behavior tracking is to monitor behaviors, not to assess for clinical signs of depression.</p>	

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	<p>anti depressant (Remeron), but lacked documentation of any behavioral symptoms or clinical indication for the use of an antidepressant medication. Resident #3 had not had an attempted gradual dose reduction of Remeron since her original admission date in 2008.</p> <p>During an observation on 2/18/14 at 10:30 a. m., Resident #3 was sitting in her room, attempting to complete a word search puzzle. Resident #3 appeared to be falling asleep with the pencil on the book. Resident #3 had a BIMS (Brief Mini Mental Survey) of 15, indicating Resident #3 had no cognitive impairment.</p> <p>During an interview on 2/20/14 at 11:00 a. m., the quality assurance nurse indicated Resident #3 had not had an attempted gradual dose reduction, due to staff reports of Resident #3 becoming emotional at times. She also indicated there were no behavioral tracking sheets completed for Resident #3, and no documented episodes of depression could be found in Resident #3's clinical record.</p> <p>During review of the "Facility Behavior/ Psychotropic Medication</p>				

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	<p>Quarterly Review" dated 2/10/14, it was indicated that the anti depressant medication Remeron, had been started on 5/19/2009 for appetite stimulation and depression. A weight obtained on 2/5/2014 indicated Resident #3 had a current weight of 211 lbs and has had no significant weight loss. A question if Resident #3 had had any episodes of worsening behavior, the question was answered, "None noted."</p> <p>4. During a record review of Resident #26's chart on 2/18/14 at 1:30 p.m., the diagnosis included, but was not limited to, depression.</p> <p>Resident #26 had a current order for Lexapro (an antidepressant medication) 10 milligrams (mg), 1 tab by mouth every day for depression with an initial order date of 1/2/13.</p> <p>Resident #26's record did not show any tracking for antidepressant medication effectiveness by staff on a regular basis for the 3 months reviewed.</p> <p>The pharmacist review for 8/19/13, presented by the Quality Assurance (QA) nurse on 2/19/14 at 1:00 p.m., Resident #26's Lexapro order was</p>			

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	<p>recorded and noted that a GDR (Gradual Dose Reduction) was not recommended due to multiple failed GDR's while admitted to the hospital.</p> <p>During an interview with the Social Service Director on 2/20/14 at 10:20 a.m., she indicated that the staff does not chart in daily tracking logs for antidepressant medications used by residents.</p> <p>5. In a policy titled "Psychotropic Medication Use:", dated 2/4/2008, provided by the QA (Quality Assurance) Nurse on 2/20/14 at 9:25 a.m:</p> <p>"...Ongoing monitoring will be in place to asses risks vs benefits of continued medication use and psychotropic medications will not be used as a restraint..."</p> <p>"...Medication classifications Antipsychotics, Sedative/hypnotics; Antidepressants and Psychopharmacological medications which include: Any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. This depends on how the medication is used and for what condition the medication is used to</p>						

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F000406 SS=D	<p>treat. This class includes anxiolytics, some anticonvulsants and some antidepressants..."</p> <p>"...2. On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the results..."</p> <p>3.1-48(a)(6)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 1 residents who required a level II assessment was reviewed for mental health services. (Resident #15).</p> <p>Findings Include: The clinical record of Resident #15</p>	F000406	F 406 Provide/Obtain Specialized Rehab Services: It is the policy of Miller's Merry Manor, Wabash West to provide or obtain from outside resources the specialized rehabilitative services needed that are identified in the resident's comprehensive plan of care. Resident #15 had no adverse effects related to this deficient practice. The respected agency has been contacted and will be	03/23/2014			

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	<p>was reviewed on 2/19/14 at 8:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, bipolar disorder, schizophrenia, diabetes, and lung disease.</p> <p>"The State of Indiana Certification of PASRR/MI Pre Admission Screening Determination", dated 6/10/11 was reviewed. PASRR/MI indicated, Resident #15 was mentally ill and required yearly review.</p> <p>The Social Service Director (SSD) was interviewed on 2/19/14 at 8:40 a.m. The SSD indicated Resident # 15 was admitted on 8/21/13 from another facility. The SSD was unaware the yearly review had not been completed. Further information was requested of the SSD regarding the yearly reviews for Resident #15.</p> <p>During an interview with the SSD on 2/19/14 at 10:05 a.m., the SSD indicated a yearly review for Resident #15 had not been completed since the initial PASARR Level II was done on 6/10/11.</p> <p>3.1-23(a)(1)</p>		<p>doing an annual review in the next 1-2 weeks. All residents requiring specialized mental health services have the potential to be affected by this deficient practice. All residents have been reviewed for their need for Level II annual assessments. Care plans have also been reviewed and updated for these residents. No other assessments are due at this time. To ensure this deficient practice does not recur, the SSD will complete an audit entitled "Social Services Needs Review" (Attachment G) monthly for 3 months, then quarterly thereafter to ensure that residents meeting Level II requirements have appropriate annual assessments completed. Any issues identified will be addressed immediately and logged on the "Quality Assurance Problem Log" (Attachment B). This will be reviewed and followed monthly in the facility QA meeting. Date of Compliance: 3/23/14.</p>	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview,</p>	F000441	F441 Infection Control: It is the	03/23/2014
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	<p>and record review, the facility failed to ensure personal care and/or glove use were preformed according to the facility infection control policy during 1 of 1 personal care observations with 1 of 1 CNA observed. (Resident #28, CNA #2) In addition, the facility failed to ensure a dressing change was completed according to the facility dressing change policy during 1 of 1 dressing change observations. (Resident #18, RN #1)</p> <p>Findings Include:</p> <p>1. Personal care for Resident #28 preformed by Certified Nursing Assistant (CNA) #2 was observed on 2/20/14 at 9:10 a.m. CNA #2 washed her hands, and took a plastic wash basin, filled with bath supplies from the resident's closet. CNA #2 took the perinal wash, disposable cloths, and lotion from the bath basin and sat them on the bedside table. She went into the bathroom and filled the wash basin with water and put on gloves. CNA #2 returned to the bedside, put two washcloths into the water and washed the resident's face. She removed the resident's hospital gown and washed, rinsed, and dried the resident's chest and axillary areas</p>		<p>policy of Miller's Merry Manor, Wabash West to establish and maintain an Infection Control Policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #28 and #18 suffered no adverse effects related to this deficient practice. All residents have the potential to be affected by this deficient practice. No other issues have been identified. RN #1 was re-educated regarding handwashing, glove use and procedure for dressing change on 2/20/14. CNA #2 was re-educated on the use of gloves, handwashing and the facility procedure for providing peri-care on 2-20-14. Education will be provided to all staff on to review infection control policies with focus on handwashing and glove usage on 3-7-14. All nurses will be required to perform skill check with return demonstration for dressing changes. All CNAs will be skill checked and will perform return demonstrations for peri-care. The facility does provide routine education per on line in-services (Silverchair) and face to face education on infection control. Routine skill checks are also done for handwashing, peri-care and dressing changes. Skill checks for staff on hand washing will be completed monthly for the next</p>		

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	<p>with the washcloths from the basin. CNA #2 applied deodorant to Resident #28's axillary areas.</p> <p>CNA #2 pulled down Resident #28's brief. CNA #2 washed the perineal area without opening the labia to completely clean the area.</p> <p>CNA #2 then assisted Resident #28 to roll onto the right side. The CNA changed her gloves, no handwashing was observed. Brown stool was observed in the resident's brief and on the resident's buttocks. CNA #2 picked up a stack of disposable cloths from the bedside and began to clean the stool. With the same gloves, CNA #2 picked up the bottle of perineal wash from the bedside table and sprayed some onto a disposable cloth. With the same gloves, the CNA continued to wash the resident's back side with the disposable cloths, picking up one clean cloth after another, spraying with the perineal wash, and washing off stool.</p> <p>CNA #2 removed the resident's brief filled with brown stool and put it into a trash bag. The CNA changed her gloves, without washing her hands, picked up the bottle of perineal wash from the bed, and put the bottle back on the bedside table.</p>		<p>three months. To ensure that infection control measures are followed according to P/P the QA Tools "Infection Control Review" (Attachment H) and "Peri-Care" (Attachment I) will be completed by the Infection Control Nurse/Designee weekly for the next four weeks and then monthly thereafter. This tool will include observation of staff during resident care procedures to ensure that gloves are worn accordingly and handwashing is completed as outlined in the facility infection control policy. Any identified issues will be addressed immediately. Concerns will be logged on the "Quality Assurance Problem Log" (Attachment B). All Quality Assurance Problem Logs are reviewed and followed by the QA Committee in the monthly facility Quality Assurance Meeting. Date of Compliance: 3-23-14.</p>				

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	<p>CNA #2 took a washcloth from the wash basin and washed the resident's bottom. More brown stool was observed on the washcloth. CNA #2 put the wash cloth with brown stool in the wash basin, took another washcloth from the water and rinsed and the resident's bottom. CNA #2 put the wash cloth on the edge of the wash basin, and dried the resident's bottom, without changing gloves.</p> <p>Without changing her gloves, CNA #2 rolled up the dirty bed pad from underneath the Resident #28, picked up a clean bed pad and clean brief from a chair and tucked both under the resident.</p> <p>Without changing her gloves, CNA #2 assisted the resident to roll, removed the dirty pad, rolled out the clean bed pad, and fastened the clean brief around the resident. CNA #2 pulled out Resident #2's oxygen tubing from under her hospital gown sleeve, put a clean gown on the resident and tied the hospital gown string behind the resident's neck.</p> <p>CNA #2 then put the dirty items into a trash bag and carried the wash basin with the dirty water into the</p>			
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	<p>bathroom. CNA #2 poured the dirty water into the bathroom sink, rinsed out the basin, wiped it dry, and removed her gloves. The CNA did not wash her hands.</p> <p>CNA #2 returned to the bedside with the wash basin. She picked up the bottle of perineal wash and remaining disposable cloths from the bedside table, put them in the wash basin, opened the closet door, and put the basin back in the closet.</p> <p>CNA #2 put on gloves, and applied lotion to the Resident #28's legs. CNA #2 then removed her gloves and washed her hands. The CNA did not sanitize the bedside table.</p> <p>The facility policy, "Peri Care" , dated 1/1/2009 was presented by the nurse consultant on 2/20/14 at 9:55 a.m. The policy indicated, "...PROCEDURE... Female...Be sure to spread the labia and cleanse thoroughly...".</p> <p>The facility Infection Control Nurse/Nurse Consultant was interviewed on 2/20/14 at 10:30 a.m. The Infection Control Nurse indicated CNA #2 should have emptied the dirty wash basin into the</p>						

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	<p>toilet instead of the bathroom sink.</p> <p>2. On 2/19/14 at 11:15 a.m. RN #1 was observed changing a wound dressing on Resident #18. RN #1 placed the bag of dressing supplies on the floor at the residents feet. RN #1 had gloves on as she raised the residents pant leg, then she took the old dressing off and placed it on the floor, then she opened the package of sterile cotton swabs. She then opened the tube of Bactroban (antibiotic ointment) and applied the Bactroban to the cotton swab then used the cotton swab to apply the Bactroban ointment to open area on left leg. RN #1 opened the packaging to the adherent dressing she then reached into her pocket for a marker and wrote 2/19/14 and her initials on new adherent dressing then placed on residents leg. RN #1 then pulled the residents pant leg down. All of that was done wearing the same pair of gloves. RN #1 then removed left glove folding old dressing, cotton swab and adhesive backing into the glove then removed glove from right hand and placed in the waste basket. RN #1 went to the resident's</p>						

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	<p>bathroom to wash hands. RN #1 washed her hands for greater than 20 seconds. RN #1 picked up the bag of dressing supplies and left the room.</p> <p>On 2/19/14 at 11:25 a.m. RN#1 indicated that she should have placed the waste basket with in reach while doing dressing change in order to throw old dressing away instead of placing it on the floor.</p> <p>On 2/19/14 at 1:30 p.m. medical record was reviewed for Resident #18. The order for the dressing change dated 2/3/14 indicated to "...apply Bactroban and non adherent dressing with Kerlix daily until healed."</p> <p>The facility policy, "Use of Medical Gloves (application and removal)", dated 6/9/2010 was presented by the nurse consultant on 2/20/14 at 11:10 a.m. The policy indicated, "...RATIONALE:... A. Medical gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident care procedures where contact may involve touching a resident's mucous membranes and non-intact skin, secretions, excretions, blood or body fluids....C. Gloves should not be</p>			

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F000520 SS=E	<p>used as a substitute for hand-washing...GUIDELINES: D. Gloves should be removed and hands washed with soap and water immediately after glove removal...".</p> <p>3.1-18(b)(2) 3.1-18(l)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed</p>	F000520	F520 QAA Committee Members/Meet Quarterly/Plans: It	03/23/2014			

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	<p>to ensure effective action plans were implemented for infection control (Resident #18, #28, RN #1 and CNA #2), effective drug monitoring (Resident #3, #15, #26, and #27) and annual resident reviews for Level II PASRR, (Resident #15).</p> <p>Findings include:</p> <p>During an interview on 2/20/2014 at 11:00 a. m., the quality assurance nurse was interviewed regarding QAA (Quality Assurance and Assessment) and the identified concerns of the annual survey as follows:</p> <ol style="list-style-type: none"> 1. During 2 of 4 direct care observations, the infection control practices were not followed, which included, but were not limited to, lack of handwashing, and/or changing of disposable gloves when soiled. (Resident #18, #28). 2. 4 of 5 residents reviewed for unnecessary medications lacked gradual dose reductions for antidepressant (Residents #3, #15, #26, and #27). 3. 1 of 1 residents reviewed for Level II compliance, lacked the 		<p>is the policy of Miller's Merry Manor West, to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least three other members of the facility staff. The quality assurance and assessment committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified deficiencies. Regarding the issues identified in the annual survey: 1. The concern of following guidelines for infection control in the observation of two staff members; one for peri care and the other for a dressing change, the nursing department did take immediate action when made aware of the concerns. The nursing assistant was re-educated on the p/p for peri care including the use of gloves and hand washing. The RN who performed the dressing change was immediately re-educated on the p/p for dressing changes including proper use of gloves and hand washing. 2. The concern regarding reduction of anti-depressant medications was also immediately addressed. Discussed with SSD and nursing. Plan to be evaluating needs for medications, attempt reductions,</p>				

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	<p>yearly review service recommendation (Resident #15).</p> <p>4. During an interview with the Administrator on 2/20/2014 at 11:00 a.m., she indicated no plan of action had been put in place to address these concerns.</p> <p>3.1-52(b)(2)</p>		<p>and documentation reviewed.</p> <p>3. The resident lacking a current level II was immediately addressed when concern was brought to facility. Contacted prior facility and also contacted agency responsible for the completion of the Level II. This has been scheduled for this resident. The care plan was also updated accordingly. There were no other identified issues. 4. In interview conducted with ADM her response was no plan of action had been put in place to address the issues. There was no prior written plan in place due to the fact these issues were identified on the annual survey. However, per facility policy all issues identified will be logged and followed through the facility QA. None of the aboved mentioned residents suffered no adverse consequences related to this deficiency. All residents have the potential to be affected, however no further issues identified. The facility conducts monthly QA meetings. Audit tools are completed by designated departments. Issues are identified and then a plan is immediately put in place and logged on the QA Problem Summary log. All logs are reviewed in the monthly QA Meeting and updated with interventions as deemed appropriate. The need for continued monitoring of issues will be determined by the QA committee. Issues will remain on</p>		

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			the logs until resolved. Issues identified in the QA meeting is provided to all staff during the monthly all staff inservice. Date of Compliance: 3-23-14 F-520 QAA Committee Miller's Merry Manor, Wabash West, respectfully requests to informally dispute F-520 via paper review. "A facility must maintain a quality assessment and assurance committee consisting of the Director of Nurses; a physician designated by the facility; and at least 3 other members of the facility staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies." Miller's Merry Manor, Wabash West has an active QAA program and committee that meets monthly with the Medical Director attending at least quarterly (Attachments A,B,C) Miller's Merry Manor, Wabash West follows QA policy and procedure (Attachment D). Quality deficiencies are identified by use of audit tools, observation, consultant reports, incidents, complaints and concerns etc. and logged on Problem logs (Attachment E). Quality Assurance and Improvement is a		

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			<p>continuous and evolving process. Good faith efforts are used to identify areas needing improvement encompassing all aspects of resident care and services, quality of life and facility operation. Unfortunately, not all areas can be identified at all times and there is always the "point of discovery" at which time a concern or issue is identified and put through the QAA process and a plan developed. This is the case with the examples cited on the 2567. Monitoring of handwashing and glove use when completed by the facility prior to survey did not present quality issues. Anti depressants used to treat signs and symptoms of depression are not reduced per facility policy so there would be no reason to include this in the QAA process as all residents are being treated appropriately and at their highest practical well being. The missed Level II was simply human error, as all other Level IIs were completed timely and recommendations followed. For these reasons, Miller's Merry Manor, Wabash West, is in compliance with F-520 in accordance with regulatory guidelines.</p>		